

November 2015

## **Case Note: Pegram v. Herdrich: HMO Physicians as Fiduciaries**

Jamie Lynn Armitage

Follow this and additional works at: <https://via.library.depaul.edu/jhcl>

---

### **Recommended Citation**

Jamie L. Armitage, *Case Note: Pegram v. Herdrich: HMO Physicians as Fiduciaries*, 5 DePaul J. Health Care L. 341 (2002)

Available at: <https://via.library.depaul.edu/jhcl/vol5/iss2/8>

This Notes & Comments is brought to you for free and open access by the College of Law at Via Sapientiae. It has been accepted for inclusion in DePaul Journal of Health Care Law by an authorized editor of Via Sapientiae. For more information, please contact [digitalservices@depaul.edu](mailto:digitalservices@depaul.edu).

## CASE NOTE: PEGRAM V. HERDRICH: HMO PHYSICIANS AS FIDUCIARIES

*Jamie Lynn Armitage*

### INTRODUCTION

A constant game of tug-of-war has waged since the implementation of health maintenance organizations ("HMOs"): on one side of the rope are the health maintenance organizations and physician subscribers pulling to manage their organizations for their own financial benefit free of fiduciary liability; on the other side of the rope are the patient beneficiaries of the HMOs seeking to hold HMOs accountable. However, the Supreme Court recently declared HMOs the winner. In *Pegram v. Herdrich*<sup>1</sup> the Court found Carle Clinic Association, P.C. ("Carle"), a health maintenance organization, and its physician owners had no fiduciary duty to its member patients.<sup>2</sup>

The Supreme Court's decision in *Pegram* has a devastating effect on the country's health care system. HMOs provide healthcare services, delivery, and financing into one prepaid capitated benefit plan.<sup>3</sup> If patient beneficiaries are unable to hold HMOs responsible, the HMO providers will continue to act in their own interest.<sup>4</sup>

---

<sup>1</sup> *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000).

<sup>2</sup> *Id.*

<sup>3</sup> See generally Edward Korneich, *Health Care M & A: Commercialization of the Medical Industry*, 741 PLI/COMM 329 (1996). See also Timothy S. Hall, *Third-Party Payer Conflicts of Interest in Managed Care: A Proposal for Regulation Based on the Model Rules of Professional Conduct*, 29 SETON HALL L. REV. 95, 103 (1998). "[C]apitation [may be used] to tie the financial incentives of the physician directly to the desired utilization rates." *Id.* "Under [this kind of contract], providers are paid a fixed amount of money for each member of the plan." *Id.* "The provider is

This article discusses *Pegram* and its consequences on the health care system. First, this article looks at a brief history of HMOs. Second, it explains the Employee Retirement Income Security Act (ERISA) of 1974 and its role in HMOs. Third, it looks at examples of state legislative action regarding the role of fiduciaries and HMOs as Congress toils with its answer. Fourth, this article explains the procedural history of the Supreme Court decision of *Pegram v. Herdrich*. Finally, this article looks at the impact of the *Pegram* on patients who want redress for HMO physicians that are motivated by their pocket books rather than patient healthcare.

## BACKGROUND

### History of HMOs *Before HMOs*

The primary goal of the managed care revolution in American health care distribution and financing was to "eliminate unnecessary and inappropriate care and to reduce costs associated with the traditional fee-for-service model."<sup>5</sup> Before HMOs, medical treatment was administered through a fee-for-service model of payment.<sup>6</sup> As a patient became ill and visited his or her physician payment was expected after the visit.<sup>7</sup> The physician would bill the patient for the services rendered, and if the patient had insurance that was accepted by the physician, the insurance would eventually pay for all or part of the treatment.<sup>8</sup> If the patient had no health insurance, the patient would

---

contractually obligated to provide certain contractually defined services to the entire patient population . . . ." *Id.* "If the provider can provide those services for less cost than the sum total of the capitation payments, it retains the excess as compensation for services rendered." *Id.* "If the provider cannot provide the designated services for less than the capitation than the physicians may be held liable for the costs." *Id.* A provider is a physician, both general practice and specialists. *Id.*

<sup>4</sup> *Pegram*, 530 U.S. at 216.

<sup>5</sup> Gisela M. Munoz et al., *Two Faces of Gag Provisions: Patients and Physicians in a Bind*, 17 YALE L. & POL'Y REV. 249, 250 (1998).

<sup>6</sup> *Pegram*, 530 U.S. at 218 (explaining that "[a] physician charges so much for a physical exam, a vaccination, a tonsillectomy, and so on.").

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

pay before leaving the office. Under "fee-for-service" health care, sick patients were left with extremely expensive medical bills.

In order to control the cost of expensive medical treatment, HMOs were created.<sup>9</sup> In effect, under the fee-for-service model physicians make money on sick people; whereas under HMOs, physicians benefit from healthy patients who pay into the HMO but have no medical bills.<sup>10</sup> Since HMOs profit from healthy subscribers who pay the member fees, HMOs provide ample preventive care.<sup>11</sup>

### *The Increasing Popularity of HMOs*

Managed care has become the primary means by which medical treatment is administered in America today.<sup>12</sup> In fact, from 1973 to 1987, the number of HMOs in existence grew from seventy-two to more than seven hundred, and even more substantial was the growth of the number of Americans covered by HMOs which grew from 3.5 million to twenty-nine million.<sup>13</sup>

The HMO Act began under the Nixon Administration in 1973 as a response to large increases in health care costs.<sup>14</sup> The Act was created to cut costs, promote preventive care, and improve care.<sup>15</sup> The first HMOs emerged on the East and West coasts: Kaiser Permanente and

---

<sup>9</sup> *Pegram*, 530 U.S. at 218.

<sup>10</sup> *Id.* at 219 (stating that the HMO assumes the financial risk of providing the benefits promised by the HMO contract: if a patient never gets sick, the HMO keeps the money, and if a patient becomes ill, the HMO is responsible for the treatment agreed upon even if the treatment costs exceed the participant's premiums).

<sup>11</sup> *Pegram*, 530 U.S. at 219.

<sup>12</sup> Hall, *supra* note 3, at 97. "In recent years, new stresses on the physician-client relationship have been created by the advent of managed care systems. Managed care attempts to realign the health care delivery system so that those who are responsible for health care costs (physicians and other providers) have incentives to take account of those costs in making treatment decisions. However, in removing the traditional incentives for limitless health care spending without regard to cost, managed care threatens to substitute a new, equally perverse incentive: the incentive to provide too little care." *Id.*

<sup>13</sup> Hall, *supra* note 3, at 100.

<sup>14</sup> RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 549 (David L. Shapiro et al. eds., The Foundation Press, Inc. 1977).

<sup>15</sup> Jason A. Glodt, *Watch Out HMOs: the Future of Patients Rights will Soon be Determined*, 45 S.D. L. REV. 640 (2000).

Group Health, respectively.<sup>16</sup> These HMOs employed physicians and employers and constructed hospitals. The enrollees paid a fixed monthly fee, and in return gained access to the facilities and professionals provided by the HMO.<sup>17</sup> However, it was not until the 1980s that HMOs became increasingly popular due to several changes to the HMO Act.<sup>18</sup> The changes included incentives to recruit Medicare and Medicaid recipients and allowed the emergence of for-profit HMOs.<sup>19</sup> The final increase in popularity came in the 1990's after Clinton's effort to introduce a national health care plan in 1994 failed to gain support and the public rejected the government's health care reform.<sup>20</sup> As a result, Americans turned to the managed care organizations for health care.<sup>21</sup>

### *HMO Organization*

HMOs are organized health care systems that finance and deliver a broad range of comprehensive health care services to its members. Originally, HMOs were financed through a prepaid fixed fee for the appropriate utilization of health care resources and delivery of care for the benefit of the patient and the health care system as a whole.<sup>22</sup> Functionally, an HMO is a combination of a health insurer and a complete health care delivery system.<sup>23</sup>

In order to carry out the goal of increasing profits and minimizing expenses, some HMOs have instituted cost containment procedures that provide physicians financial incentives to curtail referrals to specialists or non-HMO physicians, to reduce testing, and to choose the cheapest form of treatment available.<sup>24</sup> Primary care physicians are used as

---

<sup>16</sup> JAMES C. DECHENE, HEALTH CARE REIMBURSEMENT AND DELIVERY SYSTEMS, COURSE MATERIAL IN HEALTH CARE REIMBURSEMENT AND DELIVERY SYSTEM, I-1, I-4 (2000) (on file with author).

<sup>17</sup> *Id.*

<sup>18</sup> FOLLAND ET AL., THE ECONOMICS OF HEALTH & HEALTH CARE 303 (Jill Lectka ed., Macmillan Publishing Co. 1993).

<sup>19</sup> *Id.*

<sup>20</sup> See Glodt, *supra* note 15, at 641.

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d. 589, 591 (1st Cir. 1993) (stating that "HMOs often can provide healthcare at lower costs by stressing

“gatekeepers” who monitor the care of the enrollees by approving or disapproving the referral of care such as seeing specialists or the length of the patients hospital stay.<sup>25</sup> It is common for some HMO physicians to deny referrals or fail to prescribe tests in order to preserve their year-end bonuses and capitation benefits.<sup>26</sup> Some examples previously litigated include: a baby suffering from injuries in childbirth after the HMO denied the mother a much needed ultrasound because of a testing policy<sup>27</sup> and a primary care physician whose patient died because he dissuaded him from visiting a cardiologist in order to preserve the physician’s minimum referral reward.<sup>28</sup> Although courts have sanctioned some cost reduction systems; courts have held that they do not have to be disclosed to patients unless they inquire directly.<sup>29</sup>

### **Employee Retirement Income Security Act of 1974 (ERISA)**

At the heart of the *Pegram* decision is that under the Supreme Court’s holding HMOs are not liable for breach of fiduciary duty under ERISA, thus closing the door for ERISA plan beneficiaries to hold HMO physicians liable for their actions.<sup>30</sup> Simply put, physicians who work for HMOs and who treat patients under ERISA plans are not currently recognized as ERISA fiduciaries. Employers subscribe to HMOs for the benefit of their employees, and ERISA regulates and provides remedies for employee welfare benefit plans.<sup>31</sup>

---

preventative care, controlling costs and driving hard bargains with doctors or hospitals” who often obtain more patients in exchange for a reduced charge). *Id.*

<sup>25</sup> *U.S. Healthcare*, 986 F.2d at 591.

<sup>26</sup> James P. Duffy, Note, *HMO Doctors as ERISA Fiduciaries: A Bankruptcy Perspective*, 8 AM. BANKR. INST. L. REV. 125, 129-30 (2000).

<sup>27</sup> *Kampmeier v. Sacred Heart Hosp.*, No. 95-7816, 1996 U.S. Dist. LEXIS 5739 at \*1-3 (E.D. Pa. May 1, 1996).

<sup>28</sup> *Shea v. Esenstein*, 107 F.3d 625, 626-628 (8th Cir. 1997).

<sup>29</sup> *Id.* at 128-29. See also *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 755 (S.D.N.Y. 1997) (holding that there is no affirmative duty to disclose information regarding financial incentive scheme).

<sup>30</sup> Hall, *supra* note 3, at 114 (stating that ERISA imposes a fiduciary duty on administrators of covered plans).

<sup>31</sup> *Id.*

### *ERISA's Purpose*

ERISA is a federal statute that covers more than 160 million Americans.<sup>32</sup> It is a complex statutory scheme enacted in 1974 to regulate and protect private employee benefit plans.<sup>33</sup> It includes both pension and welfare plans.<sup>34</sup> A welfare plan is "any plan, fund or program maintained for the purpose of providing medical or other health benefits for employers or their beneficiaries through the purchase of insurance or otherwise."<sup>35</sup> ERISA sets uniform standards and rules relating to reporting disclosure and responsibility.<sup>36</sup> It creates specific remedies for beneficiaries who suffer a breach of fiduciary duty.<sup>37</sup> Structurally, a plan qualifies as an employee benefit plan if it is maintained pursuant to a written instrument which names a fiduciary, outlines funding, administration, and procedures for amendments and payments.<sup>38</sup> However, ERISA does not force employers to create plans, or to maintain plan benefits at consistent levels.<sup>39</sup>

Employee funded plans are generally established pursuant to ERISA and are subject to a wide range of requirements under federal law.<sup>40</sup> On the other hand, ERISA does not regulate those requirements that are common under state law like coverage and coordination.<sup>41</sup> The key distinction in determining whether state insurance laws can apply to ERISA plans is whether benefits are provided through an insurance policy purchased by the ERISA plan where the terms are subject to regulation under state insurance laws, or are directly paid by the ERISA plan that self insures where the benefits may not be subject to state insurance regulation.<sup>42</sup>

---

<sup>32</sup> Glodt, *supra* note 15, at 642-43.

<sup>33</sup> Duffy, *supra* note 26, at 132.

<sup>34</sup> *Id.* at 133.

<sup>35</sup> *Id.* (citing 29 U.S.C. § 1002(1) (1994)).

<sup>36</sup> *Id.* (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990)).

<sup>37</sup> 29 U.S.C. § 1109 (1994).

<sup>38</sup> *Id.* at 133.

<sup>39</sup> *Id.*

<sup>40</sup> See DECHENE, *supra* note 16, at I-26.

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

### *ERISA's Relevance to HMOs*

ERISA claims against the administrator of benefits can be brought in both state and federal court.<sup>43</sup> However, an action may continue in federal court even if an action is filed in state court.<sup>44</sup> American workers who participate in an employee paid HMO often cannot sue their HMO for state law actions<sup>45</sup> such as bad faith claims against insurance companies. As a result, an ERISA action to seek benefits will almost always be removed to the federal court by the defendants.<sup>46</sup> One problem created by ERISA preempting almost all state laws is that ERISA remedies are so limited that they strip beneficiaries of their ability to get damages that they otherwise would receive under state laws.<sup>47</sup> In fact, courts generally conclude that remedies for recovery of benefits under an ERISA-preempted health care plan are limited to recovery of benefits owed and possibly reasonable attorney's fees. Thus, damages such as consequential, punitive or emotional distress are not recoverable. One commentator used the following example: if an HMO denies a lung x-ray, and it is later established that the patient has undetected lung cancer, the patient can only recover the cost of the x-ray, but cannot receive any compensation for the damage caused by the delay in proper diagnosis.<sup>48</sup>

### **State Legislative Action**

Some states have taken their own legislative action on HMO liability. For example, Texas was the first of many states that passed legislation requiring an HMO to cover a hospital stay of at least two days, instead of the usual one day, for certain procedures such as childbirth.<sup>49</sup>

Many states have legislative safeguards such as the automatic right to appeal an HMO decision regarding a medical necessity of a

---

<sup>43</sup> Munoz, et al., *supra* note 5, at 269.

<sup>44</sup> *Id.*

<sup>45</sup> Some state actions will not be preempted by ERISA.

<sup>46</sup> Munoz, et al., *supra* note 5, at 269.

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> Jack E. Karns, *Litigating Around ERISA to Quality Managed Healthcare: An HMO Can Breach Fiduciary Duties*, 79 NEB. L. REV. 149, 167 (2000) (citing *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 12 F. Supp. 2d 597, 602-03 (S.D. Tex. 1998)).



particular treatment.<sup>50</sup> However, this may create more problems than it helps since it creates another layer of bureaucracy in choosing qualified mediators and arbitrators to establish a review mechanism.<sup>51</sup> Some scholars fear that state legislatures will start passing bills that guarantee a patient's right to sue an HMO, fearing the return to the days of patients paying for each treatment and fewer people with the ability to afford medical care.<sup>52</sup> State legislatures are walking a fine line between regulating the industry to benefit the patients and meddling in the private industry of HMOs.<sup>53</sup>

### Procedural History of *Pegram v. Herdrich*

#### *Facts*

Cynthia Herdrich suffered a ruptured appendix after her HMOs physician ordered her to wait eight days so she could schedule an HMO clinic.<sup>54</sup> Herdrich's health care provider consisted of three different entities which operated together to form a pre-paid health insurance plan that provides medical and hospital services to beneficiaries.<sup>55</sup> Herdrich was covered under a plan subscription through her husband's employer, State Farm Insurance Company.<sup>56</sup> Herdrich's physician, Lori Pegram, was a physician who contracted under the Carle plan.<sup>57</sup> Herdrich started having pain in the midline area of her groin.<sup>58</sup> On March 1, 1991, while Dr. Pegram treated Herdrich, she acknowledged the pain Herdrich was experiencing, but took no further action.<sup>59</sup> Six days later, Herdrich returned to the doctor and Dr. Pegram felt a six-by-eight centimeter inflamed mass in Herdrich's abdomen.<sup>60</sup> Despite the inflammation, Dr. Pegram did not immediately order an ultrasound at a local hospital in Bloomington, Illinois. Rather, Herdrich was forced to

---

<sup>50</sup> Karns, *supra* note 49, 167-68.

<sup>51</sup> *Id.* at 169.

<sup>52</sup> *Id.*

<sup>53</sup> *Id.* at 169-70.

<sup>54</sup> *Herdrich v. Pegram*, 154 F.3d 362, 365 (7th Cir. 1998).

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> *Pegram*, 530 U.S. 215.

<sup>59</sup> *Herdrich*, 154 F.3d at 365.

<sup>60</sup> *Id.*

wait eight more days<sup>61</sup> for the necessary ultrasound to be performed at a facility staffed by Carle physicians more than 50 miles away.<sup>62</sup> Before Herdrich could make it to the ultrasound at the Carle facility, her appendix ruptured and she suffered from peritonitis.<sup>63</sup> When Herdrich discovered her HMO paid bonuses to doctors who ordered fewer diagnostic tests, she sued Dr. Pegram and the HMO in state court for state medical malpractice and fraud.<sup>64</sup>

### *The District Court*

In the United States District Court for the Central District of Illinois, Defendants responded that ERISA preempted the state fraud counts and removed the matter to federal court.<sup>65</sup> In federal court, Herdrich amended her complaint to include a claim alleging that a provision of medical services under the terms of the Carle HMO that rewarded its physician owners for limiting medical care was an inherent participatory breach of an ERISA fiduciary duty.<sup>66</sup> The claim alleged that the provision breached the contract because it created an incentive for physicians to make decisions for their own financial interest, rather than in the interest of the plan beneficiaries' health.<sup>67</sup>

---

<sup>61</sup> Herdrich's medical expert stated that Herdrich's condition worsened during the eight-day waiting period "because obviously there has been another week of that appendix becoming necrotic and sitting in the pus . . . ." *Id.* at 374.

<sup>62</sup> *Pegram*, 530 U.S. at 215.

<sup>63</sup> *Id.* Peritonitis is the inflammation of the peritoneum, which is the membrane that lines the walls of the abdominal cavity.

<sup>64</sup> *Id.* Herdrich asserted that Carle violated the Illinois Consumer Fraud Act, 815 ILCS 505/1 *et seq.*, "by failing to disclose certain material facts regarding the ownership of Health Alliance Medical Plans ("HAMP"), and failing to advise her that compensation of plan physicians was increased to the extent that they did not order diagnostic tests, utilized facilities owned by those physicians, and did not make emergency or consultation referrals." Herdrich also alleged that HAMP breached its duty of good faith and fair dealing by increasing its profits and the profits of its contracted physicians to the detriment of plan beneficiaries. *Herdrich*, 154 F.3d at 366 n.2.

<sup>65</sup> *Id.* See Employee Retirement Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001-1461, preempted counts III and IV of state law fraud against Carle and successfully removed the case to federal court.

<sup>66</sup> *Herdrich*, 154 F.3d at 365.

<sup>67</sup> *Pegram*, 530 U.S. at 216.

The trial judge granted the summary motion on the state law fraud count and gave Herdrich leave to amend to clearly set forth her ERISA claim for breach of fiduciary duty.<sup>68</sup> The court later dismissed the count alleging that defendants breached their fiduciary duties in violation of ERISA.<sup>69</sup> Herdrich then appealed the dismissal of the ERISA count to the Seventh Circuit.<sup>70</sup>

### *The Seventh Circuit*

Three issues were considered by the United States Court of Appeals: first, whether the district court wrongly dismissed Herdrich's claim of a breach of fiduciary duty under ERISA; second, whether the Seventh Circuit had jurisdiction to hear the case due to Herdrich's failure to file a timely notice of appeal from the order of dismissal; and finally, the court looked at defendant's argument that Herdrich's request for damages is inappropriate insofar as beneficiaries under an ERISA benefits plan may not recover "anything other than the benefits provided expressly in the plan."<sup>71</sup>

The court found that it did have jurisdiction to hear the case since Herdrich's appeal from the trial court was not timely filed.<sup>72</sup> The court also held that Herdrich properly stated a claim under ERISA.<sup>73</sup> Furthermore, the court stated Herdrich's pleading properly stated a claim for breach of fiduciary duty under ERISA, since the facts set forth that: (1) the defendants are plan fiduciaries; (2) the defendants breached their fiduciary duties; and (3) a cognizable loss resulted.<sup>74</sup>

---

<sup>68</sup> *Herdrich*, 154 F.3d at 366.

<sup>69</sup> *Id.* The court granted Summary judgment against Herdrich on count IV "to the extent she relies on § 502(a)(3)(B) [of ERISA] as a basis for monetary relief, as opposed to equitable relief," and that provision does not provide for extra-contractual damages. *Id.*

<sup>70</sup> *Id.* at 367.

<sup>71</sup> *Id.*

<sup>72</sup> *Id.* at 367-68. Herdrich did not file within thirty days of the December 5<sup>th</sup> entry of judgment. *Id.*

<sup>73</sup> *Id.* at 369.

<sup>74</sup> *Herdrich*, 154 F.3d at 369.

The court disagreed with the district court as to whether there was a failure to allege defendants were fiduciaries.<sup>75</sup> The court held that Congress intended the definition of fiduciary to be interpreted broadly.<sup>76</sup> The court found that the “defendant physicians managed the plan, including the doctor referral process, the nature and duration of patient care.”<sup>77</sup> Also, the board of directors consisted exclusively of the plan physicians who were “in control of each and every aspect of the HMOs governance, including their own year-end bonuses.”<sup>78</sup> Furthermore, the court found that this level of “control satisfies ERISA’s requirement that a fiduciary maintain discretionary control and authority.”<sup>79</sup> As a result the court found the defendant to be a plan fiduciary.

The court went on to find that there was a breach of fiduciary duty,<sup>80</sup> and that a fiduciary breaches his or her fiduciary duty of care whenever he or she acts to benefit his or her own interests.<sup>81</sup> Drawing parallels to other cases, the court found intricacies of the defendant’s incentive structure were to benefit the defendant’s own interests.<sup>82</sup> Hence, the same HMO administrators with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses. The bonuses were based on the difference between total plan costs and gave an incentive to limit

---

<sup>75</sup> *Herdich*, 154 F.3d at 369. It is interesting to note that Herdrich originally maintained that the defendants were not plan fiduciaries and defendants insisted that they were. *Id.*

<sup>76</sup> *Id.* at 370.

<sup>77</sup> *Id.*

<sup>78</sup> *Herdich*, 154 F.3d at 370.

<sup>79</sup> *Id.*

<sup>80</sup> *Id.* at 371. “[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and-(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan; (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims . . . .” *Id.* at 371 (citing 29 U.S.C. § 1104(a)(1) (1994)).

<sup>81</sup> *Herdich*, 154 F.3d at 371 (citing James F. Forden et al., Handbook on ERISA Litigation Sec. 3.03[A], at 3-53 (1994)).

<sup>82</sup> *Herdich*, 154 F.3d at 372.

treatment to receive larger bonuses.<sup>83</sup> With a focus on year-end bonuses, it is not unrealistic to assume that the doctors prescribing care under the plan are biased.<sup>84</sup> The court was clear in holding that the decision does not make a bright line rule that where there are incentives, there is a breach of fiduciary duty; rather, incentives can be a breach of fiduciary duty where the fiduciary trust between plan participants and plan fiduciaries no longer exist.<sup>85</sup> Furthermore, the court responding to criticism by the dissent, clarifies that this decision does not mean that a fiduciary cannot have dual loyalties.<sup>86</sup> Instead, the court says, "that tolerance has its limits" and does not extend to a situation like this "where a fiduciary jettisons his responsibility to the physical well being of beneficiaries in favor of loyalty to his own financial interests."<sup>87</sup>

The court justified its decision by the policy that health care critics across the country are complaining about the quality of medical treatment that is declining because "the goal of managing care has been replaced by the goal of managing costs."<sup>88</sup> The court reasoned that since sixty percent of all managed care plans, including HMOs and preferred provider organizations, now pay their primary care doctors through some sort of capitation system,<sup>89</sup> and there is an "urgency to address the issue and hold HMOs responsible as fiduciaries."<sup>90</sup>

In summary, the Seventh Circuit noted that because the physician's year-end bonuses were based on the difference between total plan costs and revenues, an incentive existed for them to limit treatment, thereby ensuring larger bonuses.<sup>91</sup> The court concluded that

---

<sup>83</sup> *Id.*

<sup>84</sup> *Herdich*, 154 F.3d at 372.

<sup>85</sup> *Id.* at 373.

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> *Id.* at 375 (citing Jan Greene, *Has Managed Care Lost Its Soul? Health Maintenance Organizations Focus More on Finances, Less on Care*, AM. HOSP. PUBLISHING INC., May 20, 1997).

<sup>89</sup> *Herdich*, 154 F.3d 376.

<sup>90</sup> *Id.*

<sup>91</sup> *Herdich*, 154 F.3d at 372. In *Herdich's* complaint she argued: "Because the physician/administrators' year end bonuses were based on the difference between total plan costs and revenues, an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses." *Id.*

incentives can rise to the level of a breach where the fiduciary trust between plan and participants and plan fiduciaries no longer exist.<sup>92</sup> The court acknowledged that ERISA allows any plan beneficiary to sue for breach of fiduciary duty, and a fiduciary breaches his or her duty of care whenever he or she acts to the benefit of his or her own interests.<sup>93</sup>

### *The United States Supreme Court*

The Supreme Court granted certiorari and reversed the Seventh Circuit opinion holding that mixed eligibility and treatment decisions made by a HMO, acting through its physicians, were not fiduciary acts within the meaning of ERISA.<sup>94</sup>

The Supreme Court fell short of the Seventh Circuit analysis to determine whether there was a breach of fiduciary duty because the Court stopped the analysis after deciding that HMOs do not fall within the classification of a fiduciary under ERISA.<sup>95</sup> The Court found that regardless of the HMO, there must be some treatment rationing and inducement to ration treatment.<sup>96</sup> The Court stated that holding HMOs as ERISA fiduciaries would be too broad because all HMOs acting through their owner or employee physicians would have to be judged by the same standards and subject to the same claims.<sup>97</sup> The Supreme Court admitted that the relationship between withholding medical treatment and the incentive for financial award is not a subtle one. However, the Court argued that no HMO organization could survive without some incentive connecting physician rewards with treatment rationing.<sup>98</sup>

Furthermore, the Court found that a fiduciary may have dual loyalties as long as the fiduciary "wear[s] only one [hat] at a time, and wear[s] the fiduciary hat when making a fiduciary decision."<sup>99</sup> The Court held that "the specific payout of the plan was... a feature that the employer, as plan sponsor, had no fiduciary duty under ERISA, since

---

<sup>92</sup> *Herdrich*, 154 F.3d at 372.

<sup>93</sup> *Id.* (citing 29 U.S.C. § 1104(a)(1)(A) (1974)).

<sup>94</sup> *Pegram*, 530 U.S. 211, 214.

<sup>95</sup> *Id.* at 230.

<sup>96</sup> *Id.* at 221.

<sup>97</sup> *Id.* at 222.

<sup>98</sup> *Id.* at 220.

<sup>99</sup> *Pegram*, 530 U.S. at 225.

an employer's decisions about the content of a plan are not themselves fiduciary acts."<sup>100</sup> The Court found that the situation is akin to every administrative decision where a physician makes judgments about reasonable medical treatment, since making eligibility decisions and treatment decisions are inextricably mixed.<sup>101</sup> Therefore, there was no ERISA violation when the incorporators of Carle HMO provided for the year-end payout since the decision was administrative.<sup>102</sup>

The Court determined that the issue of whether HMOs are held as fiduciaries was not a judicial decision, but rather a Congressional decision: "If Congress wishes to restrict its approval of HMO practice to certain preferred forms, it may choose to do so."<sup>103</sup> The Court determined that HMOs came into existence because of groups of physicians were consistently providing more medical treatment than necessary.<sup>104</sup> The Court stated that it would be too easy to allege an economic influence seemingly adverse to the patient whenever an outcome was not a good one, and feared this would makes HMOs a "guarantor of recovery."<sup>105</sup>

Finally, the Court found the Seventh Circuit's holding of fiduciary breaches limited to situations where the sole purpose of delaying or withholding treatment was to increase the physician's financial reward was problematic.<sup>106</sup> The first problem the court had with the limited holding was that the "tactical" defense HMO physicians would use would be that he or she was not acting for his or her financial interest but for good medical reasons.<sup>107</sup> This defense would require reference to standards of reasonable and customary medical practice in like circumstances,<sup>108</sup> and would play out in court as a malpractice action.

---

<sup>100</sup> *Pegram*, 530 U.S. at 226.

<sup>101</sup> *Id.* at 229.

<sup>102</sup> *Id.*

<sup>103</sup> *Pegram*, 530 U.S. at 233-34.

<sup>104</sup> *Id.*

<sup>105</sup> *Id.* at 233-34.

<sup>106</sup> *Id.* at 235.

<sup>107</sup> *Pegram*, 530 U.S. at 235.

<sup>108</sup> *Id.*

## ANALYSIS

### HMO Physicians as Fiduciaries

In *Pegram* the Court determined that HMO physicians are not fiduciaries to beneficiaries,<sup>109</sup> despite the overwhelming similarities that HMO physicians have to other legally recognized fiduciaries. This decision is alarming to patients who are now left with no redress for the actions of HMOs. The Court refused to hold HMO physicians as fiduciaries despite the fact that HMO owner physicians not only fall under the standard definition of fiduciary, the HMO-beneficiary relationship resembles other fiduciary relationships, and HMO physicians fall within Congress' statutory definition of fiduciary under ERISA.

Blacks Law Dictionary defines fiduciary as, "one who owes to another a duty of good faith, trust, confidence, and candor."<sup>110</sup> Patients expect "good faith, trust, confidence and candor" in their physician. If a physician is being persuaded or influenced by an HMO plan then patients expect the same standards from the HMO physicians. Furthermore, a fiduciary relationship is a "relationship that exists when one person is under a duty to act for the benefit of the other on matters within the scope of the relationship."<sup>111</sup> Fiduciary relationships arise in one of four situations: (1) when one person places trust in the faithful integrity of another, who as a result gains superiority or influences over the first; (2) when one person assumes control and responsibility over another; (3) when one person has a duty to act for or give advice to another on matters falling within the scope of the relationship; or (4) when there is a specific relationship that has traditionally been recognized as involving fiduciary duties.<sup>112</sup> An HMO and physician most notably fall under the third category because the physicians has a duty to act for or give advice to another on matters falling within the scope of the HMO plan that creates the relationship and they are acting as an agent for the HMO. In fact, the contractual relationship gives

---

<sup>109</sup> *Pegram*, 530 U.S. at 216.

<sup>110</sup> BLACKS LAW DICTIONARY 625-26 (6th ed. 1999).

<sup>111</sup> *Id.*

<sup>112</sup> See *In re Estate of Heilman*, 345 N.E.2d 536, 540 (Ill. App. Ct. 1976).



color to the argument that the HMO and physician have a fiduciary relationship with the beneficiary under the second category listed above. Contractually, physicians assume control and responsibility over all health care decisions and treatments for the beneficiaries of the HMO. Finally, the relationship also fits under the fourth category since the HMO physician-beneficiary relationship is analogous to other fiduciary relationships recognized by law. Some examples of those relationships traditionally recognized as having a fiduciary duty are trustee-beneficiary, guardian-ward, agent-principal, and attorney-client.

### *Trustee-Beneficiary*

The trustee-beneficiary interest is similar to HMO physician-beneficiary because the superior authority whether by possession of money or knowledge has complete or at least partial control over the interests of the beneficiary. Just as the trustee must make decisions that directly affect the beneficiary, the decisions that the physician makes in regard to the HMO plan have a direct impact on the health and well being of the patient beneficiary. However, in an HMO-patient relationship the beneficiary also benefits from the HMO in that they pay a low fee for unlimited amount of treatment. Nonetheless, if the patient does not get sick the employer still pays the same premium. In *Pegram*, the Court says the analogy between the ERISA fiduciary and common law trustee becomes problematic because, "the trustee at common law characteristically wears only his fiduciary hat when he takes action to effect the beneficiary, whereas the trustee under ERISA may wear different hats."<sup>113</sup> The Court further says that trustees, unlike HMO physicians, would violate their duty if they placed themselves in a position that would be for his own benefit.<sup>114</sup> However, Dr. Pegram was wearing her "fiduciary hat" when she ordered Herdrich to wait eight days before traveling to a far away HMO clinic.<sup>115</sup> In fact, Pegram was wearing her "fiduciary hat" as soon as Herdrich stepped into her medical office for an evaluation of her ailment. Also, Herdrich's claim is toward the Carle HMO as a whole<sup>116</sup> and not

---

<sup>113</sup> *Pegram*, 530 U.S. at 225.

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> *Id.* at 216.

against Dr. Pegram for failing to make a prudent decision. Dr. Pegram was acting as the decision maker and was the one that scheduled the ultrasound a full eight days after noticing the mass.<sup>117</sup> There was no one above Dr. Pegram that made these decisions. Dr. Pegram was the plan manager and should be personally responsible along with the Carle HMO.

Likewise, having a personal interest in an agreement or relationship is quite different than acting for one's own interest once in that relationship. In order for a relationship to be successful neither one of the parties can be self-serving. Thus, although physicians in HMOs can have a financial interest in entering into an HMO, they should not have to choose between care for their patients and their own financial benefit. To do so would be devastating to the millions of patients that are at the mercy of these HMO physicians.

### *Guardian-Ward*

The guardian-ward relationship parallels the HMO physician-beneficiary relationship, and serves a compelling reason that HMOs should be ERISA fiduciaries. A ward is a minor who is under a guardian's charge or protection or "placed under the care and supervision of a guardian or conservator."<sup>118</sup> Similarly, a patient is like a minor because the patient does not have the skill or expertise that the physician has in making treatment decisions. There is such a strong dependency from the minor to the guardian that the guardian is a "protector." Physicians, too, should protect their patients because there is a strong dependency from the patient to the physician. HMO physicians should have a fiduciary duty to use their expertise to protect patients from incurring preventable diseases like the Peritosis Cynthia Herdrich developed.

### *Agent-Principal*

The agent-principal relationship, which has long been recognized as a fiduciary relationship, also has many characteristics of an HMO

---

<sup>117</sup> *Pegram*, 530 U.S. at 215.

<sup>118</sup> BLACKS LAW DICTIONARY, *supra* note 109, at 1583.

physician-beneficiary relationship.<sup>119</sup> A principal authorizes another to act on his or her behalf as an agent, but the principal has primary responsibility on the obligation. Agency is a legal concept which depends upon the existence of three elements: (1) the manifestation by the principal that the agent shall act for him; (2) the agent's acceptance of the undertaking; and (3) the understanding of the parties that the principal is to be in control of the undertaking.<sup>120</sup> The intent of the parties does not in itself create the agency.<sup>121</sup> There are similarities between an agent- principal relationship and a HMO-physician relationship. The HMO contracts with the physician to ensure the physician will be the one performing the medical services for the HMO in return for payment. Thus, the HMO, as principal, manifests that the physician will act for it, and the physician agrees by signing the contract. The HMO and physician agree that the HMO plan will dictate the relationship with the patient and the treatment given. In an agent-principal relationship, the principal is held responsible for the agent's action. Since the HMO and physician meet the criteria of an agent-principal relationship, the HMO should be liable for the physician's actions.

### *Attorney-Client*

Also, the HMO physician and beneficiary relationship is like the attorney-client relationship. The attorney-client relationship is fiduciary as a matter of law.<sup>122</sup> This is because of the high standards lawyers are held to, such as zealous advocacy, competency and confidentiality.<sup>123</sup> The medical profession is held to similar standards. In order to sanctify and preserve the profession, physicians should be held to the utmost duty of care and loyalty that is inherent in the fiduciary duty. Therefore, physicians (acting through their HMOs) should be held accountable, just as attorneys are held to the Model Rules of

---

<sup>119</sup> See *Morris Oil Co. v. Rainbow Oilfield Trucking, Inc.*, 741 P.2d 840 (N.M. Ct. App. 1987).

<sup>120</sup> See *id.*

<sup>121</sup> See *id.*

<sup>122</sup> See James Coomes, *The Scope of Lawyer Liability to Limited Partners Arising Out of a General Partner's Breach of Fiduciary Duty*, 22 J. LEGAL PROF. 231, 232 (1998).

<sup>123</sup> *Id.*

Professional Conduct.<sup>124</sup> In fact, some scholars suggest that HMO physicians should be held to the same standard as attorneys in the situation of third party payers.<sup>125</sup> "If a third party pays for legal services rendered to another, the lawyer is only allowed to accept the representation on these terms if the client consents after full disclosure and if the lawyer reasonably believes that the third party payer will not affect the lawyer's professional judgment on behalf of the client."<sup>126</sup> "If the disinterested lawyer would not believe that the latter requirement is satisfied, the lawyer is ethically prohibited from accepting the representation on the terms offered, even if the client, after full disclosure of the conflict of interest, is willing to accept representation on those terms."<sup>127</sup> Similarly, if a physician reasonably believes that receiving a year-end bonus or other HMO compensation will effect his treatment decisions for his patient, he should not accept the bonus or the patient. Physicians in HMOs should be held accountable to the plan that patient beneficiaries believe they have entered into, one that will protect the patient, not offer financial incentives to physicians.<sup>128</sup>

### *The Physician's Fiduciary Duty*

A physician is held to a strict fiduciary duty to his beneficiary patients.<sup>129</sup> There are at least three reasons why a physician has this duty: first, the relationship between a doctor and patient has long been

---

<sup>124</sup> Hall, *supra* note 3 at 96.

<sup>125</sup> *Id.* at 96-97.

<sup>126</sup> *Id.* at 97.

<sup>127</sup> *Id.*

<sup>128</sup> *Id.* at 98. "This article proposes that such a rule be applied to physicians entering into contractual relationships with managed care organizations." Hall, *supra* note 3, at 98. "Such a rule would benefit physicians and patients." *Id.* "It would recognize first, that the principle of freedom of contract does not apply well to patient-physician relationships, because of the imbalance of expertise, necessity of trust in the physician, and the nature of managed care contracts as adhesion contracts." *Id.* Second, it would restore the physician to the position of protector of the patient's best interest. *Id.* "The physician would have an affirmative ethical obligation not to enter into managed care relationships in which a disinterested physician would not agree that the inherent conflicts of interest can be resolved in harmony with the best interests of the patients." *Id.*

<sup>129</sup> Munoz et al., *supra* note 5, at 258.

recognized as a contractual relationship; second, under tort law a doctor is liable for medical malpractice if he or she fails to provide the care of a reasonable physician in like circumstances; and third, law recognizes the fiduciary relationship because the doctor is a voluntary undertaker acting for the patients benefit.<sup>130</sup> Many physicians now are HMO providers. Therefore, just as the above reasoning for physician's fiduciary status, the HMO now serves as the fiduciary. Thus, the three situational relationships that create a duty between physicians and their patients, contract, tort law, and voluntary undertaking, should be passed on to the HMO. The fiduciary duty should be passed on through contract because many patients and their employers now contract with the HMOs rather than the physicians directly. The relationship from physicians to patients should be identical to the HMO-patient relationship in tort law because the HMOs influence the member physician's decisions in providing patient care. For example, Dr. Pegram did not order an immediate ultrasound at the local hospital because if she waited for the Carle facility she would contribute to her year-end bonus; therefore, the HMO motivated her decision to delay treatment. Finally, the presumption that the physician possesses superior knowledge of medical diagnosis and services should likewise apply to HMOs because HMOs set the parameters for which the physicians base their treatment decisions.

### *Congress Anticipated HMOs under ERISA*

The statutory definition of ERISA fiduciary drafted by Congress allows HMOs to be held as fiduciaries. HMOs are not mentioned because HMOs did not exist in the statutory language when ERISA was established in 1974, but under ERISA Congress could have anticipated something like an HMO to fall under the statutory definition of a fiduciary for the following reasons.

The Supreme Court in *Pegram* states, "The question is whether that person was performing a fiduciary function when taking the action subject to the complaint and not whether the actions were adverse to the beneficiary."<sup>131</sup> The Court says that this is because "Congress was

---

<sup>130</sup> *Id.* at 262-263.

<sup>131</sup> *Pegram*, 530 U.S. at 226.

unlikely to have thought of these decisions as fiduciaries.”<sup>132</sup> However, Congress delineates the definition of a fiduciary in ERISA, and HMO physician’s decisions fit the definition. Under ERISA, “A fiduciary is someone acting in the capacity of manager, administrator, or financial adviser to a plan.”<sup>133</sup> Dr. Pegram was the administrator of the Carle plan. The American Heritage Dictionary defines “manager” as “one who directs, controls or handles.”<sup>134</sup> Dr. Pegram controlled the doctor appointment by examining the patient and by further directing the patient to wait eight days before getting further tests at a far away hospital owned by Carle.<sup>135</sup> Also, an “administrator” is defined as “someone who manages business affairs.”<sup>136</sup> Arguably, Dr. Pegram was “managing the affairs” of the HMO in the interest of Dr. Pegram and other owners of Carle’s financial benefit and plan when she made the management decision to wait the eight days for further testing at a Carle facility.<sup>137</sup> An “advisor” is “one who recommends or suggests.”<sup>138</sup> Dr. Pegram acted as an “advisor” because she recommended that Herdrich wait eight days to get tested at the Carle-owned hospital located forty-five minutes away.<sup>139</sup> Herdrich followed what her doctor recommended like most patients that rely on their physician’s knowledge and expertise.<sup>140</sup> The Circuit Court itself defined “plan” as a “scheme decided on in advance.”<sup>141</sup> The Carle HMOs scheme was to encourage frugal treatment in order to receive the year-end bonus.<sup>142</sup>

### The Seventh Circuit’s Test

Furthermore, the Supreme Court rejected the Seventh Circuit’s test that there is a breach of fiduciary where the sole purpose of delaying

---

<sup>132</sup> *Id.* at 231.

<sup>133</sup> 29 U.S.C. § 1104(a)(1) (1994).

<sup>134</sup> THE AMERICAN HERITAGE DICTIONARY 504 (3rd ed. 1999).

<sup>135</sup> *Pegram*, 530 U.S. at 215.

<sup>136</sup> THE AMERICAN HERITAGE DICTIONARY, *supra* note 209, at 11.

<sup>137</sup> *See Pegram*, 530 U.S. at 215. *See also Herdrich*, at 362, 365 n.1.

<sup>138</sup> THE AMERICAN HERITAGE DICTIONARY, *supra* note 209, at 13.

<sup>139</sup> *See Pegram*, 530 U.S. at 215.

<sup>140</sup> *Id.*

<sup>141</sup> *Herdrich*, 154 F.3d at 369.

<sup>142</sup> *Id.* at 372.

treatment is for a financial award.<sup>143</sup> The Seventh Circuit felt comfortable with implementing this distinction, stating it best by saying: "With a jaundiced eye focused firmly on year-end bonuses, it is not unrealistic to assume that the doctors rendering care under the plan were swayed to be most frugal when excising their discretionary authority to the detriment of their membership."<sup>144</sup> A physician who finds an abdominal mass and waits eight days to provide the proper test at an HMO provider hospital to receive a year-end bonus is not acting in their patient's best interest. Rather, the physician is fulfilling the plan's objectives while also lining his own pockets.

The Supreme Court strayed far from the Seventh Circuit's majority and dissenting opinions in declaring that HMOs can never rise to the breach of a fiduciary duty.<sup>145</sup> The unanimous opinion written by Justice Souter stated by declaring the Carle HMO had breached its duty of loyalty and trust to the participating patients because of the purely financial incentive of delaying the treatment of Herdrich's appendix opens the door to declaring this breach on all HMOs.<sup>146</sup> Since all HMOs have some sort of financial incentive involved, "inducement to ration care is the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others."<sup>147</sup> The Court found that making a distinction between good and bad HMOs would embody a judgment about socially acceptable medical risk that would turn on facts not readily accessible to courts.<sup>148</sup> However, distinguishing between good and bad HMOs is easily discernable. The nine Supreme Court Justices are not medical doctors educated and

---

<sup>143</sup> *Pegram*, 530 U.S. at 234-35.

<sup>144</sup> *Herdrich*, 154 F.3d at 372. The court sets out the intricacies of the defendants' incentive structure set forth in their claim. *Id.* "The plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians were those physicians who became eligible to receive year-end bonuses were based on the difference between total costs (i.e., the costs of providing medical services) and revenues (i.e. the costs of providing medical services) and revenues (i.e., payments by plan beneficiaries), and incentive existed for them to limit treatments and, in turn, HMO costs so as to ensure larger bonuses." *Id.*

<sup>145</sup> *See Pegram*, 530 U.S. at 236-37.

<sup>146</sup> *Id.*

<sup>147</sup> *Id.* at 221.

<sup>148</sup> *Id.*

skilled in determining diagnoses or determining when and how to effectively treat patients; yet, the Court only had to determine whether the physician allowed his or her judgment to be affected by his desire for a larger bonus. A logical test to use to answer the question would be a reasonable physician standard. If a reasonable physician treating the same symptom would prescribe a treatment at a specific time and place, the failure to do so would be inherently suspect in situations in which the physician is on an incentive plan like in *Pegram*.

### CONCLUSION

The Supreme Court declared HMO physicians the winners of the tug-of-war in *Pegram*, and found that HMO physicians were not fiduciaries. However, HMO physicians fall under the definition of fiduciaries to their patients, and therefore should be held accountable to HMO beneficiaries. The Court in numerous relationships similar to the HMO physician and beneficiary relationship such as guardian-ward, attorney-client, trustee-beneficiary, etc. has confirmed a fiduciary relationship. Rather than a comparative analysis, the Court made generalizations about HMOs as a whole, and stopped short of distinguishing those HMOs that should be held as fiduciaries and are motivated by financial incentives from those that are not. Some HMOs deserve less protection from liability than others. For example, an HMO that gives year-end bonuses for withholding treatment that a reasonable physician would prescribe in similar circumstances should be held as a fiduciary. It is only when the Court allows HMOs to be held to the high fiduciary standard as non-HMO physicians that patients will feel safe with their HMO-physicians treatment decisions.



